MDR Tracking Number: M5-05-1142-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 12-14-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The level III office visits and manual therapy techniques from 12-30-03 through 03-03-04 as well as the therapeutic exercise and neuromuscular re-education from 12-30-03 through 02-16-04 **were** found to be medically necessary. The level III office visits and manual therapy techniques from 03-05-04 through 04-12-04 as well as the therapeutic exercises and neuromuscular re-education from 02-18-04 through 04-12-04 **were not** found to be medically necessary. The respondent raised no other reasons for denying reimbursement for level III office visits, therapeutic exercises, neuromuscular re-education and manual therapy techniques. The amount due from the carrier for the medical necessity issues equals $6,859.46.

This Findings and Decision is hereby issued this 12th day of May 2005.

Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees for dates of service 12-30-03 through 03-01-04 totaling $6,859.46 in accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202(c), plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order.

This Order is hereby issued this 12th day of May 2005.

Medical Necessity Team Manager
Medical Review Division

Enclosure: IRO decision

January 27, 2005

Texas Workers Compensation Commission
MS48
7551 Metro Center Drive, Suite 100
Austin, Texas 78744-1609

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-05-1142-01
TWCC #:
Injured Employee:
Requestor: Work & Accident Clinic
Respondent: Hammerman & Gainer
MAXIMUS Case #: TW05-0001

MAXIMUS has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The MAXIMUS IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to MAXIMUS for independent review in accordance with this Rule.

MAXIMUS has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the MAXIMUS external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The MAXIMUS chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to MAXIMUS for independent review. In addition, the MAXIMUS chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 20 year-old male who sustained a work related injury on ___. The patient reported that while at work he injured his right shoulder when a box fell on him. An MRI of the right shoulder performed on 12/17/03 revealed a possible 5mm synovial cyst or labral cyst contacting the anterosuperior glenoid labrum, labral tear may not be excluded, and mild AC joint bony hypertrophy. X-rays of the cervical, thoracic, and lumbar spine performed on 11/3/03 revealed straightening of the usual or expected cervical and lumbar lordosis that may reflect

muscular pain or spasm. The diagnoses for this patient have included right shoulder strain contusion, and low back strain. Treatment for this patient's condition has included muscle relaxants, pain medications, and physical therapy, therapeutic exercises, manual therapy techniques, and neuromuscular reeducation.

Requested Services

Level III office visits, therapeutic exercises, neuromuscular reeducation, manual therapy techniques from 12/30/03 through 4/12/04.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Chart Note 2/5/04
2. MRI report 12/17/03
3. X-Ray report 11/3/03
4. Progress and Treatment notes 12/4/03 – 4/27/04

Documents Submitted by Respondent:

1. Same as above

Decision

The Carrier's denial of authorization for the requested services is partially overturned.

Rationale/Basis for Decision

The MAXIMUS chiropractor reviewer noted that this case concerns a male who sustained a work related injury to his right shoulder on ___. The MAXIMUS chiropractor reviewer indicated that the patient was treated with three months of therapy with little to no results when he switched treating doctors. The MAXIMUS chiropractor reviewer explained that 6-8 weeks of active and passive therapy, with positive results being shown, is medically necessary. However, the MAXIMUS chiropractor reviewer noted that after 2/16/04, the patient had plataued. The MAXIMUS chiropractor reviewer indicated that after two weeks of the patient not demonstrating any improvement, treatment is no longer medically necessary unless the treatment plan is changed. The MAXIMUS chiropractor reviewer explained that the treatment plan for this patient did not change after the patient had plataued. The MAXIMUS chiropractor reviewer indicated that the treatment this patient received did not facilitate him returning to work without restrictions. The MAXIMUS chiropractor reviewer explained that the patient ended treatment with a lifting restriction of 10lbs. The MAXIMUS chiropractor reviewer explained that at the time the patient had plataued with treatment, he could have been released to a home exercise program. Therefore, the MAXIMUS chiropractor consultant concluded that the levell III office visits, and manual therapy techniques were medically necessary to treat this patient's condition from 12/30/03 through 3/3/04. The MAXIMUS chiropractor consultant also concluded that the therapeutic exercise, and neuromuscular reeducation were medically necessary to treat this patient's condition from 12/30/03 through 2/16/04.

However, the MAXIMUS chiropractor consultant further concluded that the level III office visits and manual therapy techniques from 3/5/04 through 4/12/04 were not medically necessary to treat this patient's condition and that the therapeutic exercise, and neuromuscular reeducation from 2/18/04 through 4/12/04 were not medically necessary to treat this patient's condition.

Sincerely,
MAXIMUS

Elizabeth McDonald
State Appeals Department